CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/09/2011 FORM APPROVED OMB NO. 0938-0391

I I		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		155628	B. WIN			08/25/20	ווע
NAME OF F	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE		
BRIARWOOD HEALTH AND REHABILITATION CENTER					CENTRAL AVE		
				L	APOLIS, IN46205		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F0000	REGGERIORI OR	ESC IDENTIFIEND IN ORIGINATION)		1710			DATE
1.0000							
	This visit was for	r a Recertification and	F0	000		İ	
	State Licensure s	survey.					
		J.					
	Survey Dates: A	August 22, 23, 24 and 25,					
	2011						
	Facility Number:	: 009569					
	Provider Number	r: 155628					
	Aim Number:	200139920					
	Survey Team:						
	Diana Zgonc, RN	N TC					
	Connie Landmar	ı, RN					
	Christi Davidson	ı, RN					
	Courtney Hamilt	ton, RN					
	Census Bed Type	e:					
	SNF/NF:	92					
	Total:	92					
	Census Payor Ty	rpe:					
	Medicare:	9					
	Medicaid:	76					
	Other:	7					
	Total:	92					
	Stage 2 Sample	33					
		es reflect state findings					
	cited in accordan	nce with 410 IAC 16.2.					
	Quality review c	ompleted on August 30,					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE	•	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T5PO11

Facility ID: 009569

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628			(X2) MULTI A. BUILDIN B. WING		OO	(X3) DATE S COMPL 08/25/20	ETED
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE CENTRAL AVE		
BRIARW	OOD HEALTH AND	REHABILITATION CENTER			POLIS, IN46205		
(X4) ID		TATEMENT OF DEFICIENCIES	П	- 1	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAU	2011 by Bev Fau		I.F.	10			DATE
F0225 SS=D	The facility must in have been found or mistreating resistance had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities.	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an awould indicate unfitness for a aide or other facility staff to de registry or licensing					
	violations involving abuse, including ir and misappropriat reported immediat the facility and to with State law through	nsure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are ely to the administrator of other officials in accordance ough established procedures tate survey and certification					
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.					
	reported to the addrepresentative and accordance with S State survey and oworking days of the violation is verified action must be taken						
	and interview, t	d review, observation, he facility failed to s (injury of unknown	F0225	5	 The bruise on Resident # has resolved. All resident have the potential to be affected. A facility wide 	-	09/24/2011

009569

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155628	B. WIN			08/25/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				CENTRAL AVE	
BRIARW	OOD HEALTH AND	REHABILITATION CENTER			APOLIS, IN46205	
					711 0210, 114 10200	1
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		DATE
	1 – ′	ely manner for 1 of 1			in-service was held to review entire incident reporting proc	
	resident with br	ruising (Resident # 76).			The in-service included the	
					requirement that all facility	
	Findings includ	e:			employees are responsible to	0
					immediately notify their	
	During an inter	view on 8/22/11 at 2:00			immediate supervisor and th	• • • • • • • • • • • • • • • • • • •
	P.M., with Resi				written notification will includ	
	•	ad 3 bruises on her			time and date of the incident	
		not remember how she			well as the reporting date/time. The direct supervisor is	IC.
		bruising was observed			responsible to immediately n	otify
	1 ~	s right forearm and			the Administrator of the	,
		black in color. The			incident.4. A monthly audit v	vill be
		ed the information to			conducted by the	
	•				Administrator/designee of all	
	the nurse at tha	at time.			incidents and a report will be	
	<u></u>				prepared for the QA Committee.5. Correction da	to:
		Resident # 76 was			9/24/2011	. c .
	reviewed on 8/2	24/11 at 3:30 P.M.			0/2 1/2011	
	Diagnoses for I	Resident # 76 included				
	but were not lin	nited to				
	Cerebrovascula	ar Disease,				
	Hypertension, I	Dementia, Esophageal				
		sive Disorder and				
		o Cerebrovascular				
	Disease.					
	During review o	of the Incident Report				
		eviewed on 8/25/11 at				
	11:00 A.M., the					
	l '					
		of the incident being				
	1 .	24 hours according to				
		cy. The Incident Report				
		3/11, but the fax				
		ocument was dated				
	8/24/11 at 16:0	7 (4:07 P.M.).				

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155628 08/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3640 N CENTRAL AVE BRIARWOOD HEALTH AND REHABILITATION CENTER INDIANAPOLIS, IN46205 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE During an interview with the Administrator on 8/25/11 at 10:50 A.M., she indicated we were in the process of doing an investigation and not sure if it needed to be reported so we missed the 24 hour time frame that it should have been reported. 3.1-28(c) The facility must develop and implement F0226 written policies and procedures that prohibit SS=D mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1. The bruise on Resident #76 F0226 09/24/2011 Based on record review, observation, has resolved. 2. All residents and interview, the facility failed to have the potential to be report 3 bruises (injury of unknown affected. 3. A facility wide origin) in a timely manner according to in-service was held to review the their current facility policy for 1 of 1 entire incident reporting process. The in-service included the resident with bruising (Resident #76). requirement that all facility employees are responsible to Findings include: immediately notify their immediate supervisor and the The record for Resident #76 was written notification will include the time and date of the incident as reviewed on 8/24/11 at 3:30 P.M. well as the reporting date/time. The direct supervisor is Diagnoses for Resident #76 included responsible to immediately notify but were not limited to the Administrator of the Cerebrovascular Disease. incident.4. A monthly audit will be conducted by the Hypertension, Dementia, Esophageal Administrator/designee of all Reflux, Depressive Disorder and incidents and a report will be Aphasia due to Cerebrovascular prepared for the QA Disease. Committee.5. Correction Date: 9/24/2011 During an interview on 8/22/11 at 2:00

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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Facility ID: 009569

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155628		(X2) MULTI A. BUILDIN B. WING		OO	(X3) DATE S COMPL 08/25/2	ETED	
	OF PROVIDER OR SUPPLIED		36	640 N (DDRESS, CITY, STATE, ZIP CODE CENTRAL AVE		
		REHABILITATION CENTER	IIN	NDIANA	APOLIS, IN46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL SLESC IDENTIFYING INFORMATION)		FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	arm and could got them. The to the resident was purple and resident report the nurse at the During review provided and reported within the facility policy was dated 8/23 confirmation do 8/24/11 at 16:00 During an interest Administrator of A.M., she indices process of doing not sure if it new missed the that it should he had provided by 8/25/11 at 11:00 "Procedure: Or reported Facilities are resident."	nad 3 bruises on her not remember how she bruising was observed is right forearm and diblack in color. The ed the information to at time. of the Incident Report eviewed on 8/25/11 at execord lacked of the incident being 24 hours according to cy. The Incident Report B/11, but the fax ocument was dated 17 (4:07 P.M.).					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155628		A. BUILDING	E CONSTRUCT 00	TION	(X3) DATE S COMPL 08/25/2	ETED	
	ROVIDER OR SUPPLIER		STR. 364	0 N CENTR		1 00.20.2	
	SUMMARY S (EACH DEFICIEN REGULATORY OR of occurrence t Division the that all alleged injuries of unknown of the following (A) the source observed by an of the injury could the resident; ar (B) the injury is of the extent of location of the injuries observed by an of the extent of location of the injury is of the extent of location of the injuries observed by an of the injury is of the extent of location of the injuries observed by an of the injury is of the extent of location of the injuries observed by an of the injury is of the extent of location of the injuries observed by an of the injury is of the extent of location of the injuries observed by an of the injury is of the extent of location of the injuries observed by an of the injury is of the extent of location of the injuries observed.	REHABILITATION CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) o the Long Term Care facility must ensure violations including own source are diately to the f the facility and to n accordance with gh established Unknown Source d be classified as an wn source when both conditions are met: of the injury was not ny person or the source uld not be explained by nd s suspicious because the injury or the injury or the number reved at one particular the incidence of	364	O N CENTR IANAPOLIS	AL AVE	1	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155628	B. WING		08/25/2011	
NAME OF I	DROWINED OR CUIDDLIER			ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER		3640 N	CENTRAL AVE		
BRIARW	OOD HEALTH AND	REHABILITATION CENTER	INDIAN	IAPOLIS, IN46205		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
F0279	A facility must use	*	IAG		DAIL	
SS=D	,	velop, review and revise the				
00-D		hensive plan of care.				
		levelop a comprehensive resident that includes				
		tives and timetables to meet				
		al, nursing, and mental and				
		ds that are identified in the				
	comprehensive as	ssessment.				
	The care plan mus	st describe the services that				
	· ·	d to attain or maintain the				
		practicable physical,				
		nosocial well-being as				
		83.25; and any services that				
		e required under §483.25				
	•	ed due to the resident's under §483.10, including the				
		atment under §483.10(b)(4).				
	-	rd review and interview,	F0279	The care plans for Resident	ent 09/24/2011	
		d to develop and		#19 were reviewed and upda		
	•	are plan for a resident		as needed.2. All residents h	I	
	transfer from th	•		the potential to be affected. transfer needs of all residen		
	wheelchair bas	ed on an assessment		have care plans reviewed ar		
		ith a two person		updated as needed.3. All nu		
		for 1 resident in a		will be in-serviced on initiatir	·	
	' '	ole of 33 residents		and completing care plans the	I	
		are plans. (Resident		reflect the transfer needs of residents.4. The DON or	me	
	#19)			designee will review 5 reside	ent	
	,			care plans monthly times thr	ree	
	Findings include:			months, then quarterly there		
				to determine if resident's car plans reflect the transfer nee	I	
	The record for Resident #19 was reviewed on 08/24/11 at 2:44 p.m. Diagnoses included, but were not		the residents. Any concerns	I		
			be reported to the QA Comn	nittee		
			for further action.5. Correcti	on		
			date: 9/24/2011			
	limited to lower	gastrointestinal bleed,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T5PO11

Facility ID:

009569

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155628	B. WINC			08/25/2	011
		1			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	₹		3640 N	CENTRAL AVE		
BRIARW	OOD HEALTH AND	REHABILITATION CENTER			APOLIS, IN46205		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	history of cereb	oral vascular accident,					
	hypertension, of	depression and					
	Diabetes Mellit	us Type II.					
	A quarterly Mir	nimum Data Set (MDS)					
	Assessment, d	` ,					
	· ·	dent #19 was a two or					
		hysical assist when					
		m bed to wheelchair.					
		ated, in reference to					
		seated to standing					
		<u> </u>					
	' '	ent # 19, "Not					
	1 ' '	ole to stabilize with					
		nce" The MDS					
	1	dent #19 had upper and					
	lower extremity	/ impairment to one					
	side.						
	1	apy evaluation, dated					
	02/04/11, indic	ated, "Reason for					
	Referral: Acut	e decline in mobility,					
	safety. No lone	ger able to ambulate					
		c] assist of 2 for					
	bed<>wc [bed	•					
	wheelchair to b	· ·					
		nair - The patient is					
	able to safely t	•					
	1						
		air requiring maximum					
	· -	mes] 2 [6-99% assist					
	with 2 people].	"					
	A mnc	o for Decident 440					
		e for Resident #19,					
	dated 08/10/11 at 17:12 (5:12 p.m.),						
	· · · · ·	dicated, "CNA was					
	transferring res	sident from a sitting					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		ľ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	LETED	
		155628	B. WIN	IG		08/25/2	2011
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•	
		DELIADII ITATION CENTED			CENTRAL AVE		
		REHABILITATION CENTER			APOLIS, IN46205		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710		side of the bed to her	-	1110			DITE
	'	r]. Using gait belt					
	assist, resident						
	· ·	NA let resident to the					
	floor onto knee	s"					
	A care plan, da	ted 06/27/11, titled,					
	"Falls," indicate	ed, "Potential for falls					
		A [cerebral vascular					
	accident] with (, • • •					
	hemiparesis an						
	1	lent will remain free					
	from fallsAss	ist with all transfers"					
	\	tod 00/10/11 indicated					
	•	ted 08/19/11, indicated					
		eeded physical to impaired transfer					
	skills.	to impaired transfer					
	OKIIIO.						
	 During an inter	view on 08/25/11 at					
		rding getting resident					
		the wheelchair, CNA					
		esident #19 was a one					
	person physica	l transfer. CNA #1					
	' ' '	lent #19 can pivot.					
	_	view with the Director					
		N) on 08/25/11 at 10:05					
		an specific to Resident					
	#19's transfers	was requested.					
	_	view on 08/25/11 at					
		DoN indicated CNA's					
		nstructions on daily					
	assignment she	eets. The DoN					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155628	B. WIN	G		08/25/2	011
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
					CENTRAL AVE		
BRIARW	OOD HEALTH AND	REHABILITATION CENTER		INDIAN	APOLIS, IN46205		
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PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	•	prior to 08/10/11,					
		vas a stand, pivot and					
		was a one person					
		er according to the					
	provided at this	further care plans were					
	provided at this	s ume.					
	The record lack	ked documentation of					
		plan of care for two					
		I transfers from the					
		air, or wheelchair to					
	bed to wricelon	an, or wheelerian to					
	bed.						
	3.1-35(a)						
	3.1-35(b)(1)						
F0323	,	nsure that the resident				l	l
SS=D		ins as free of accident					
		sible; and each resident					
	devices to prevent	e supervision and assistance					
	· ·	rd review and interview,	F ₀	323	The Certified Nursing		09/24/2011
		d to use a two person			Assistant assignment sheets		
					were reviewed and updated.	2. All	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155628	B. WIN	IG		08/25/2	011
NAME OF	PROVIDER OR SUPPLIEF	- {	-	1	ADDRESS, CITY, STATE, ZIP CODE		
				1	CENTRAL AVE		
BRIARW	OOD HEALTH AND	REHABILITATION CENTER		INDIAN	APOLIS, IN46205		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	+	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1 ' '	for transferring from			residents have the potential affected.3. The Certified Nu		
		wheelchair for 1 of 2			Assistants were in-serviced	ising	
	residents revie				concerning checking their		
	accidents/haza	irds in a stage two			assignment sheets to ensure	the	
	sample of 33.				appropriate transfer method	is	
	(Resident #19)			used during transfer. All		
					residents transfer needs will reviewed to ensure the	pe	
	Findings includ	le:			appropriate transfer is being		
					used. The Certified Nursing		
	The record for	Resident #19 was			Assistant assignment sheets	will	
	reviewed on 08	3/24/11 at 2:44 p.m.			be updated as necessary.4.		
		•			or designee will audit 5 resid		
	Diagnoses incl	uded, but were not			transfer needs per week time two months to ensure the	es	
	1 -	gastrointestinal bleed,			appropriate transfer methods	sare	
	1	oral vascular accident,			in place and are correct on the		
	1	depression and			Certified Nursing Assistant		
	Diabetes Mellit	-			assignment sheets. The results		
	Blabetes Weint	do Type II.			of the audit will be presented	l at	
	Δ quarterly Min	nimum Data Set (MDS)			the monthly QA Committee meeting and any		
	Assessment, d	•			recommendations made will	be	
	1	dent #19 was a two or			followed.5. Correction Date:		
		hysical assist when			9/24/2011		
		n bed to wheelchair.					
		ated, in reference to					
	_	seated to standing					
	1 '	ent # 19, "Not					
		ole to stabilize with					
		nce" The MDS					
		dent #19 had upper and					
	1	impairment to one					
	side.						
	1	apy evaluation, dated					
	02/04/11, indic	ated, "Reason for					

009569

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155628	B. WIN			08/25/2	011
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE	•	
		REHABILITATION CENTER		<u> </u>	APOLIS, IN46205		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	Referral: Acute safety. No long and requies [sid bed<>wc [bed to wheelchair to bed<>Wheelchair to bed<>wheelchair to bed<>wheelchair to bed<>wheelchair to bed<>wheelchair to bed<>wheelchair to bed<>perpension of the with 2 people) A care plan, da "Falls," indicate related toCV/accident] with (hemiparesis and mobilityResident from fallsAssidered 08/10/11 titled, "Fall," indicated 08/10/11 titled, "Fall," indicated resident position on the w/c [wheelchair assist, resident balance and Cf floor onto kneed of the wide of	e decline in mobility, ger able to ambulate classist of 2 for to wheelchair, ed]Transfer: fair - The patient is cansfer from fair requiring maximum fines] 2 (76-99% assist" Ited 06/27/11, titled, for falls are considered as a considered with all transfers" Itel of Resident #19, at 17:12 (5:12 p.m.), licated, "CNA was ident from a sitting side of the bed to her cl. Using gait belt stood and lost NA let resident to the s"		TAG			DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155628		(X2) MULT A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE S COMPL 08/25/2	ETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3	640 N (DDRESS, CITY, STATE, ZIP CODE CENTRAL AVE APOLIS, IN46205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	23:27 (11:27 p. Order Note," in was here to get resident for pail Acetaminopher During an interes:25 a.m., regating the better the better the person physicated Residuals and the indicated CNA's instructions on sheets. The Dette to 08/10/11, Residuals and the person physicated CNA's instructions on sheets. The Dette to 08/10/11, Residuals and the person physicated CNA's instructions on sheets. The Dette to 08/10/11, Residuals and the person physicated CNA's instructions on sheets. The Dette to 08/10/11, Residuals and the person person person physicate the person	view on 08/25/11 at rding getting Resident ed to the wheelchair, ed Resident #19 was a vsical transfer. CNA #1 lent #19 can pivot. view on 08/25/11 at Director of Nursing shave transfer daily assignment on indicated that prior esident #19 was a d transfer, which was a vsical transfer					